

EMDR Intensive Client Workbook

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SECTION 1: What you need to know about EMDR intensives, and your EMDR intensive experience

SECTION 2: What is EMDR?

EMDR Therapy is a powerful tool to reduce symptoms of trauma, PTSD, anxiety, and depression. It helps the brain to process and heal from life-altering events by unlocking stored memories and promoting psychological flexibility.

Because the memory or memories are not appropriately stored, symptoms persist in the present – nightmares, flashbacks, anxiety, depression, and high levels of reactivity. Post-traumatic stress disorder (PTSD) is the diagnosis often given to those who suffer persistent effects of trauma; however, trauma effects can manifest through anxiety and depression as well.

The impacts of trauma are pre-cognitive. In the words of Bessel van der Kolk (2014), “the body keeps the score.” Why do we respond so viscerally to certain triggers, no matter how often we tell ourselves our responses are irrational? Because those responses are stored on a deep, neurological level – a level that is pre-rational. Conventional talk therapy can’t touch those responses.

Those responses are not your fault – they were formed as adaptive measures to ensure your safety when you were threatened or traumatized. But the effects continue to impact your life. Body-oriented, comprehensive trauma therapy – Eye Movement Desensitization and Reprocessing (EMDR) – is the way to address those traumas, reduce those responses, and massively improve your quality of life. We’ve seen it happen so many times, and we know it can happen for you. It is one of the most-researched and tested forms of therapy and is one of the few approved evidence-based treatments used by the Veteran’s Administration (VA) to treat PTSD.

The theory behind EMDR is the adaptive information processing (AIP) theory, as developed by Francine Shapiro, the founder of EMDR. AIP posits that mental health





symptoms originate from maladaptively stored traumatic experiences, and that for healing to occur, those experiences and memories have to be processed fully and then linked up to adaptive information. EMDR is the process that facilitates this. For example, an adult who suffered sexual abuse at the hands of a caregiver may have the maladaptive belief that they are to blame for their experience, and that they are shameful and flawed as a result. This belief leads to symptoms for this adult like low self-worth, depression, use of substances, and other self-harm behavior. When the traumatic memories of the abuse are processed using EMDR, the memories can link to the adaptive beliefs of “I am not to blame” and “I am a decent person,” for example. The intense feelings of shame and low self-worth are reduced and the adult feels less depressed.

EMDR combines bilateral stimulation (BLS) – either eye movements (following your therapist’s fingers or a light on a light bar), tactile stimulation (either holding buzzers or self-tapping on your knees or shoulders), or auditory stimulation (alternating beats played through headphones) – with 45-60 second periods of connecting with the targeted traumatic memory. Trauma is stored in fragmentary pieces in the brain – cognitions, emotions, body sensations, and images are stored in different places, not fully processed and, therefore, still able to be triggered. Non-traumatic memories do not tax the memory processing systems and therefore do not get “stuck.”

A metaphor that is often used to explain the experience of the trauma processing sets is that of being on a train, sitting next to the window. While you are processing with the BLS running, memories, images, thoughts, etc. are moving past you and you can see them clearly through the window, but you are not experiencing them. Every time we end a set, it’s like getting off at a train stop, checking in with what’s happened (briefly), and getting on again to continue the processing. **You are free to stop the processing at any point.**

We will continue to process in this way until a target memory is no longer disturbing to you. Since most people have several related targets to process during an intensive, once we have fully resolved a target memory, we will move on to the next target. One thing I stress to all clients is: there is no such thing as doing EMDR “wrong.” We will work together to find the most productive way to approach your treatment.





Section 3: Negative Cognitions List

Directions: Look at this list of negative cognitions. Circle as many as you feel apply to you – that you believe about yourself or have believed about yourself at different times in your life. After going through the list, try to pick the **top five** that you feel like come up for you the most frequently in your present life. With each of your top five, pick an early memory that relates to this negative cognition – when do you remember first "learning" this to be true about yourself? (Example: I am stupid – perhaps you first learned this when your teacher belittled you in front of the class in 2nd grade)

Theme: Control/choice
I do not have control of my life.
I am weak.
I am powerless.
I cannot succeed.
I will fail/ I am a failure.

Theme: Safety/vulnerability
I am in danger.
I cannot stick up for myself.
I can't trust anybody.
I can't trust myself.
I cannot protect myself.

Theme: Perfectionism/self-defectiveness
I should be better.
I did something wrong.
I should have done more.
I should have known better.





I should be more like _____.

Theme: Responsibility

I am not worthy.
I am unlovable.
I am defective.
I am stupid.
I deserve to die.
I am insignificant.
I am a bad person.
It's my fault.

Top Five:

1.

First learned:

2.

First learned:

3.

First learned:

4.

First learned:

5.





First learned:

Section 4: Developmental History

Directions: For each of the life stages below, write a few sentences that summarize that stage. For the earlier life stages – the ones you don't remember – share the major story or narrative that you were told about yourself at that stage.

Infancy:

Toddlerhood:

Preschool:

Elementary School:





Middle School:

High School:

Young Adulthood:

Adulthood/Current:





Section 5: Attachment Inventory

What is attachment? Attachment theory focuses on relationships and bonds (particularly long-term) between people, including those between a parent and child and between romantic partners. It is a psychological explanation for the emotional bonds and relationships between people.

This theory suggests that people are born with a need to forge bonds with caregivers as children. These early bonds may continue to have an influence on attachments throughout life.

Directions: For each of the attachment figures listed below, give five adjectives to describe them, and a primary memory that you associate with them - positive or negative. You may include one of both, if that feels appropriate. You may not identify as having all of these attachment figures, and that is okay. Just respond to the ones that feel applicable to you.

Primary Caregiver 1:

Primary Caregiver 2:

Other important caregiver (babysitter, grandparent, aunt/uncle/cousin, older sibling, coach, teacher, etc.):





First romantic partner:

Current romantic partner:

Other important attachment figures, if any:





Section 6: Primary triggers and symptoms

Directions: In the chart below, list all of the primary triggers you notice and the primary symptoms you are experiencing, and give any of the additional details requested that you can.

Trigger or symptom	Thoughts	Body sensations	Emotions	Intrusive Images	Other important details
Ex: baby can't be soothed	I'm a terrible mother	Dropping sensation in belly, tight shoulders	Despair, failure, shame, guilt	Myself trying to calm her in the midde of the night and I can't	Sometimes I just leave in her in her crib and I feel so guilty
Ex. Can't get out of bed	I'm such a loser, I'm lazy	Heaviness in my chest, sleepiness	Shame, disgust, sadness		





Section 7: Aspects of self / roles

You may have heard the term “parts” before. We all have parts of ourselves - aspects of us that are triggered or activated by different situations or experiences. Take some time to explore the following parts of you (if applicable), by answering the following questions for each part:

1. Does this part have a name or title?
2. How old is this part?
3. What is this part’s job?
4. How did it get that job?
5. How does it feel about that job?

Example: my “mom” part, about 40. Her job is to know everything about child development and be up to date on all of the most recent parenting knowledge, strategies, and research. She feels like she has to meet all of her kids’ needs and is terrified of screwing up. She feels pulled in a million directions and struggles to prioritize what to do first. She loves her kids with every fiber of her being but is also thisclose to burning out. She got this job because this is what society tells her a mom is supposed to be, and what her mother modeled for her. She’s completely overwhelmed by this job but doesn’t believe that anyone else can take enough off her plate to help her feel balanced.

Parent:

Child:

Student:





Employee:

Friend:

Pet owner:

Teenager (i.e. when do you feel yourself acting like a teenager? Lots of us have a rebellious teen inside):

Partner:

Athlete:

Crafter:

Spiritual/religious part:

Angry part:





Anxious part:

Traumatized part:

Fearful part:

Etc - other parts of you that feel significant:





Section 8: Treatment Goals

Now that you've completed all of these exercises, go back and review them. Notice how you feel, what thoughts are coming up, how your body feels. And with that information, let's map out your treatment goals.

What are your top 3 goals for your intensive treatment?

1.

2.

3.

What are some emotions, body sensations, and beliefs about yourself that you would like to experience both LESS of and MORE of? Example: I'd like to feel less anxious and more self confident. I'd like the tightness in my chest to occur less frequently. I'd like to believe I am worthy of love.

Emotions:

Body Sensations:





Beliefs about self:

Section 9: Resource Identification

Directions: Given the treatment goals you've identified above, please identify the following:

1. Safe/calm place or memory that is relevant to your treatment goals. For example, if you are coming to treatment for postpartum depression, come up with at least one positive parenting memory or experience you can easily access - a time when you felt connected to your child or confident in your parenting ability. This can be a micro-moment, as long as it feels positive. **It's ok if you struggle to identify this. We can work on it together.**

2. Given your treatment goals, who might be a figure or figures - real or imagined, who can be a source of support, nurturance, protection, and/or wisdom for you when you are feeling potentially overwhelmed during our EMDR work? To use the postpartum depression example again, who might be a figure who supports you as a parent and sees the best in you as a parent that you may struggle to see yourself? What might this person say to you? I.e. your grandmother or a close friend who always reminds you of how kickass you are as a parent.

3. What are 2 or 3 things that bring you peace, joy, and/or contentment? Examples: knitting, going for walks, cuddling with your cat, reading, taking a nap on the beach, trying new foods, watching a favorite TV show over and over, etc.





Section 10: Between Intensive Days

Since EMDR processing is intended to “stir up the junk” in your mind and body, it’s likely - and actually positive - for you to notice an uptick in some symptoms, some rumination, the impact of some triggers, etc. - between intensive days. In my experience, this happens most often between the first intensive day and the second, but can happen at any time. Remember, you’ve “kicked the hornet’s nest” - we’re getting at stuff you may never have touched before, and your nervous system and your defense mechanisms may launch into overdrive.

First things first, use your resources - the ones we developed together in our intensive. There’s also a handout at the end of this workbook that lists a whole bunch of grounding techniques that you can use for self-soothing either in therapy or when you’re on your own. Try a few out, see which ones work best for you. I’d also love to know which ones are working best for you, so I can make sure to use those with you in our sessions as well.

Second, if you can, I’d like you to record those moments when you noticed your activation increasing, using essentially the same format as you did when we talked about symptoms that are particularly distressing. I’ll paste it here again on the next page.





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Ex: baby can't be soothed	I'm a terrible mother	Dropping sensation in belly, tight shoulders	Despair, failure, shame, guilt	Myself trying to calm her in the midde of the night and I can't	Sometimes I just leave in her in her crib and I feel so guilty
Ex. Can't get out of bed	I'm such a loser, I'm lazy	Heaviness in my chest, sleepiness	Shame, disgust, sadness		

Third, I'd encourage you to do some dream journaling. A few sentences in the morning after you wake up, just noticing what came up in your dreams. Freud said that our dreams are the "Royal Road to the unconscious", and while there's a lot of things I don't love about Freud, I do think he was on to something with that. And certainly, if you have a dream that feels like a flashback, or is directly relevant to our work, please take note.





Section 11: After Your Intensive

First of all, congratulations! You completed a difficult but hopefully transformative process that can be a monumental shift in your healing journey. I'd encourage you to spend some time, once a week for the month after your intensive, looking back at the treatment goals you set in this workbook and noticing what comes up in your mind and body when you re-read them. Record your responses in a couple of sentences.

Week 1:

Week 2:

Week 3:

Week 4:

Finally, we will have decided, at the end of our last day, how I will check in with you a month after your intensive - whether you would prefer email or phone. I will follow up with any medical or mental health providers you would like me to contact about our work





together as well. It's been an honor and a privilege to share this time and space with you.



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GROUNDING TECHNIQUES

to use in session with clients

Mindfulness

- Noticing your feet on the floor or your back against the chair
- Noticing the texture of your sweater/the couch/ a blanket/ a stuffed animal
- Pick out three things in the office that you like - name the details of each
- Pull out your wallet and look at your license - notice the date, your age, your picture - tell yourself - this is me, and it is 2023, and I am 37 (or whatever)

Physical Activities

- Do 5 jumping jacks or 5 toe touches (do with your client!)
- Play catch with a soft ball
- Do a few easy yoga stretches - mountain pose, up to the sky, down to the ground. I am not a yogi! Any stretching is great.

Breathing Exercises

- in through your nose for five seconds, hold it for two seconds then breathe out through pursed lips (like an "ahh" sound) for 10 seconds. Repeat this cycle three times before taking a break if needed.
- *Counting breaths while focusing on each breath helps keep things calm during stressful situations; try counting to 10 over and over again until you feel calmer.
- *Take deep breaths into your belly instead of chest area; this will help calm down any tension or anxiety.

Sensory Activities

- Eating a peppermint (keep a stash in your office! Nothing fancy)
- Smell flowers in your office
- Smelling an essential oil, dabbing it on your wrist - peppermint, eucalyptus, citrus work particularly well.
- Peel and eat an orange and notice all of the sensations - smell, feel, taste
- Notice ambient or environmental noises
- Splash cold water on your face
- Drink ice water or a hot drink (tea, hot chocolate, coffee)



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